		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041426

Facility Name: Wynscape

Address: 2180 West Manchester Road (Number) Wheaton (City) 60187 (Zip Code)

County: DuPage

Telephone Number: (630) 665-4330 **Fax #** (630) 665-3181

IDPA ID Number: 363436685001

Date of Initial License for Current Owners: 3/1/1996

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics **Telephone Number:** (847) 259-7373, Ext. 111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Paul C. Piro
(Title) Treasurer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Patrick Szajkovics, Senior Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 3315 W.Algonquin Rd. S-110, Rolling Meadows IL 60008
(Telephone) (847) 259-7373 Fax # (847) 259-9869

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,243	3,791	17,734	32,768	8
9	SNF/PED					9
10	ICF	18,064	15,258		33,322	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,307	19,049	17,734	66,090	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.64%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 15,206

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	456,606	24,986	9,841	491,433		491,433		491,433			1
2	Food Purchase		353,513		353,513		353,513		353,513			2
3	Housekeeping	308,680	30,745	74,379	413,804		413,804		413,804			3
4	Laundry	103,060	15,215		118,275		118,275		118,275			4
5	Heat and Other Utilities			246,433	246,433		246,433	3,530	249,963			5
6	Maintenance	66,738	9,292	74,775	150,805		150,805	112,475	263,280			6
7	Other (specify):*											7
8	**TOTAL General Services**	935,084	433,751	405,428	1,774,263		1,774,263	116,005	1,890,268			8
	B. Health Care and Programs											
9	Medical Director			40,450	40,450		40,450		40,450			9
10	Nursing and Medical Records	5,016,393	306,504	53,672	5,376,569		5,376,569		5,376,569			10
10a	Therapy	832,719	9,694	50,094	892,507		892,507		892,507			10a
11	Activities	173,358		8,005	181,363		181,363		181,363			11
12	Social Services	179,226		3,778	183,004		183,004		183,004			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,201,696	316,198	155,999	6,673,893		6,673,893		6,673,893			16
	C. General Administration											
17	Administrative	131,089		798,499	929,588		929,588	(282,839)	646,749			17
18	Directors Fees											18
19	Professional Services			22,046	22,046		22,046	27,140	49,186			19
20	Dues, Fees, Subscriptions & Promotions			15,471	15,471		15,471	2,455	17,926			20
21	Clerical & General Office Expenses	245,745	36,922	71,693	354,360		354,360	144,457	498,817			21
22	Employee Benefits & Payroll Taxes			1,845,516	1,845,516		1,845,516	147,780	1,993,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,667	12,667		12,667	3,714	16,381			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			609,385	609,385		609,385		609,385			26
27	Other (specify):*											27
28	**TOTAL General Administration**	376,834	36,922	3,375,277	3,789,033		3,789,033	42,707	3,831,740			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,513,614	786,871	3,936,704	12,237,189		12,237,189	158,712	12,395,901			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wynscape #0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			549,951	549,951		549,951	(37,611)	512,340			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			211,938	211,938		211,938	(31,441)	180,497			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,797	40,797		40,797		40,797			35
36	Other (specify):*											36
37	**TOTAL Ownership**			802,686	802,686		802,686	(69,052)	733,634			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		516,312		516,312		516,312		516,312			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,742	114,742		114,742		114,742			42
43	Other (specify):*			219,973	219,973		219,973	(136,655)	83,318			43
44	**TOTAL Special Cost Centers**		516,312	334,715	851,027		851,027	(136,655)	714,372			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,513,614	1,303,183	5,074,105	13,890,902		13,890,902	(46,995)	13,843,907			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(102,094)	30		9
10	Interest and Other Investment Income	(31,441)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(270)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,000)	43		24
25	Fund Raising, Advertising and Promotional	(92,385)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,375)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (271,565)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	224,570		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 224,570		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,995)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5A**

Wynscape

ID# **0041426**

Report Period Beginning: **7/1/2003**

Ending: **6/30/2004**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of State Travel	$ (718)	24	1
2	Finance Charges	(657)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,375)		49

Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	0
Line 21	(657)
Line 22	0
Line 23	0
Line 24	(718)
Line 25	0
Line 26	0
Line 27	0
Line 28	(1,375)
Line 29	(1,375)
Line 30	(102,094)
Line 31	0
Line 32	(31,441)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(133,535)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	(136,655)
Line 44	(136,655)
Line 45	(271,565)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wynscape # 0041426 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,530	0	0	0	0	0	0	0	0	0	3,530	5
6	Maintenance	0	112,475	0	0	0	0	0	0	0	0	0	112,475	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	116,005	0	0	0	0	0	0	0	0	0	116,005	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(282,839)	0	0	0	0	0	0	0	0	0	(282,839)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,140	0	0	0	0	0	0	0	0	0	27,140	19
20	Fees, Subscriptions & Promotions	0	2,455	0	0	0	0	0	0	0	0	0	2,455	20
21	Clerical & General Office Expenses	(657)	145,114	0	0	0	0	0	0	0	0	0	144,457	21
22	Employee Benefits & Payroll Taxes	0	147,780	0	0	0	0	0	0	0	0	0	147,780	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(718)	4,432	0	0	0	0	0	0	0	0	0	3,714	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,375)	44,082	0	0	0	0	0	0	0	0	0	42,707	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,375)	160,087	0	0	0	0	0	0	0	0	0	158,712	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wynscape # 0041426 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(102,094)	64,483	0	0	0	0	0	0	0	0	0	(37,611)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,441)	0	0	0	0	0	0	0	0	0	0	(31,441)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(133,535)	64,483	0	0	0	0	0	0	0	0	0	(69,052)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(136,655)	0	0	0	0	0	0	0	0	0	0	(136,655)	43
44	**TOTAL Special Cost Centers**	(136,655)	0	0	0	0	0	0	0	0	0	0	(136,655)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(271,565)	224,570	0	0	0	0	0	0	0	0	0	(46,995)	45

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Central DuPage Health System	100			Central DuPage Hospital	Winfield, IL	Hospital
				CNS Home Care	Carol Stream, IL	Home health
See attached listing for Board of Directors summary.				Wyndmere Retire	Wheaton, IL	Ret. Community
				PAHCS II	Winfield, IL	Occupatnl Med
				DuPage Hlth Svc	Winfield, IL	Lab
				CD Health	Winfield, IL	Pharmacy

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Central DuPage Health System	100.00%	$ 3,530	$ 3,530	1
2	V	6	Maintenance		Central DuPage Health System	100.00%	112,475	112,475	2
3	V	17	Administrative Services		Central DuPage Health System	100.00%	515,660	515,660	3
4	V	19	Legal and Professional Fees		Central DuPage Health System	100.00%	27,140	27,140	4
5	V	20	Licenses, Dues, Fees, etc		Central DuPage Health System	100.00%	2,455	2,455	5
6	V	21	Clerical and General Office		Central DuPage Health System	100.00%	145,114	145,114	6
7	V	22	Employee Benefits		Central DuPage Health System	100.00%	147,780	147,780	7
8	V	24	Travel and seminar		Central DuPage Health System	100.00%	4,432	4,432	8
9	V	30	Depreciation		Central DuPage Health System	100.00%	64,483	64,483	9
10	V								10
11	V								11
12	V	17	Management fees	798,499	Central DuPage Health System	100.00%		(798,499)	12
13	V								13
14	Total			$ 798,499			$ 1,023,069	$ * 224,570	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Central DuPage Health System
Street Address: 27W353 Jewell Road
City / State / Zip Code: Winfield, IL 60190
Phone Number: (630) 933-5023
Fax Number: (630) 933-1728

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated costs	369,540	9	$ 105,561	$	12,357	$ 3,530	1
2	6	Maintenance	Accumulated costs	369,540	9	3,363,590		12,357	112,475	2
3	17	Administrative services	Accumulated costs	369,540	9	15,420,966	15,420,966	12,357	515,660	3
4	19	Legal and professional fees	Accumulated costs	369,540	9	811,628		12,357	27,140	4
5	20	Dues, licenses & subscriptions	Accumulated costs	369,540	9	73,426		12,357	2,455	5
6	21	Clerical and general office	Accumulated costs	369,540	9	4,339,670		12,357	145,114	6
7	22	Employee benefits	Accumulated costs	369,540	9	4,419,422		12,357	147,780	7
8	24	Travel and seminar	Accumulated costs	369,540	9	132,536		12,357	4,432	8
9	30	Depreciation	Accumulated costs	369,540	9	1,928,389		12,357	64,483	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 30,595,188	$ 15,420,966		$ 1,023,069	25

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Health Care Associates		X	Mortgage Note	$60,195.00	1/1/2000	$ 7,029,000	$ 6,637,185	12/31/24	0.0925	$ 211,938	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$60,195.00		$ 7,029,000	$ 6,637,185			$ 211,938	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(31,441)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31,441)	14
15	TOTALS (line 9+line14)						$ 7,029,000	$ 6,637,185			$ 180,497	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wynscape COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0041426

CONTACT PERSON REGARDING THIS REPORT Jeff Hebreard

TELEPHONE (630) 933-5023 FAX #: (630) 933-1728

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A	N/A	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,390 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2000	$ 1,800,000	1
2					2
3	TOTALS			$ 1,800,000	3

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209		2000		$ 5,726,808	$ 144,779	40	$ 143,170	$ (1,609)	$ 644,266	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Elevator			7/1/1996	2,468		20	128	128	934	9
10	Facility project number 96071, See 12C for breakout			6/30/1997							10
11	General construction project number 96007			6/30/1997	154,315	1,851	40	3,858	2,007	28,935	11
12	Demolition			6/30/1997	14,620		40	366	366	2,745	12
13	Construction debris removal			6/30/1997	18,783		40	470	470	3,525	13
14	Excavation			6/30/1997	4,356		40	109	109	818	14
15	Concrete			6/30/1997	28,710		40	718	718	5,385	15
16	Unit masonry			6/30/1997	39,480		40	987	987	7,403	16
17	Rough carpentry			6/30/1997	1,488		40	37	37	278	17
18	Temporary protection cleanup			6/30/1997	10,767		40	269	269	2,018	18
19	Wood doors			6/30/1997	7,043		40	176	176	1,320	19
20	Spray on fire proofing			6/30/1997	11,800		40	295	295	2,213	20
21	Membrane roofing			6/30/1997	95,011		40	2,375	2,375	17,813	21
22	Metal door and frames			6/30/1997	14,369		40	359	359	2,693	22
23	Wood replacement doors			6/30/1997	4,381		40	110	110	825	23
24	Entrances and storefront			6/30/1997	28,398		40	710	710	5,325	24
25	Aluminum windows			6/30/1997	127,610		40	3,190	3,190	23,925	25
26	Hardware			6/30/1997	38,367		40	959	959	7,193	26
27	Interior glazing			6/30/1997	8,750		40	219	219	1,643	27
28	Drywall			6/30/1997	471,593		40	11,790	11,790	88,425	28
29	Ceramic tile			6/30/1997	34,909		40	873	873	6,548	29
30	Resilient flooring			6/30/1997	35,834		40	896	896	6,720	30
31	Floor prep			6/30/1997	1,809		40	45	45	338	31
32	Painting			6/30/1997	38,007		40	950	950	7,125	32
33	Toilet and bath accessories			6/30/1997	20,015		40	500	500	3,750	33
34	Kitchen and building allowance			6/30/1997	118,968		40	2,974	2,974	22,305	34
35	Window treatment allowance			6/30/1997	19,238		40	481	481	3,608	35
36	Storage / Moving			6/30/1997	1,748		40	44	44	330	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Final cleaning allowance	6/30/1997	$ 11,225	$	40	$ 281	$ 281	$ 2,108	37
38	Field investigation	6/30/1997	900		40	23	23	173	38
39	Fire protection	6/30/1997	17,701		40	443	443	3,323	39
40	Plumbing	6/30/1997	155,685		40	3,892	3,892	29,190	40
41	HVAC	6/30/1997	24,900		40	623	623	4,673	41
42	Electrical	6/30/1997	322,774		40	8,069	8,069	60,518	42
43	Fire alarm system	6/30/1997	13,741		40	344	344	2,580	43
44	Premium time drywall	6/30/1997	2,366		40	59	59	443	44
45	Reconstruction fee	6/30/1997	28,000		40	700	700	5,250	45
46	Fees to Schall Brothers	6/30/1997	72,379		40	1,809	1,809	13,568	46
47	Insurance	6/30/1997	17,277		40	432	432	3,240	47
48	Millwork	6/30/1997	61,115		40	1,528	1,528	11,461	48
49	Architect fees	7/31/1997	150,000		5			150,000	49
50	Architectural reimbursement	7/31/1997	10,952		5			10,952	50
51	Survey	7/31/1997	7,956		5			7,956	51
52	City permit fees	7/31/1997	4,886		5			4,886	52
53	Legal (contract only)	7/31/1997	6,927		5			6,927	53
54	Contingency fees	7/31/1997	36,385	2,241	10	3,639	1,398	23,654	54
55	Testing services	7/31/1997	10,864		5			10,864	55
56	Title insurance	7/31/1997	346		1			346	56
57	Landscaping	7/31/1997	45,000		5			45,000	57
58	Fence	7/31/1997	4,287	735	7	735		4,226	58
59	Balance of landscaping	10/23/1997	15,000	1,623	10	1,500	(123)	9,750	59
60	Seal stripe parking lot	10/28/1997	2,959		3			2,959	60
61	Elevator repairs	1/13/1998	11,000		20	565	565	3,605	61
62	Security system	2/3/1998	2,318		10	251	251	1,545	62
63	Elevator repairs	7/1/1998	1,500		3			1,500	63
64	Elevator repairs	11/18/1998	7,942		3			7,942	64
65	Gas water heater	11/10/1998	2,657		3			2,657	65
66	Smoke detectors	1/11/1999	2,225		3			2,225	66
67	Elevator repairs	1/13/1999	27,293		3			27,293	67
68	Elevator repairs	2/8/1999	6,349		3			6,349	68
69	Plumbing repairs	4/28/1999	700		3			700	69
70	TOTAL (lines 4 thru 69)		$ 8,165,254	$ 151,229		$ 201,951	$ 50,722	$ 1,366,269	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,165,254	$ 151,229		$ 201,951	$ 50,722	$ 1,366,269	1
2	Rear door repairs	5/15/1966	2,799		3			2,799	2
3	Prior year improvement to facility project number 96071:								3
4	General contractor cost	6/30/1997	145,836	17,349	40	3,646	(13,703)	30,991	4
5	Construction insurance	6/30/1997	10,702	1,273	40	268	(1,005)	2,278	5
6	Fire alarm system	6/30/1997	8,717	1,037	40	218	(819)	1,853	6
7	Electrical work	6/30/1997	69,239	8,236	40	1,731	(6,505)	14,714	7
8	HVAC improvement work	6/30/1997	394,855	46,969	40	9,871	(37,098)	83,904	8
9	Plumbing improvement	6/30/1997	86,233	10,258	40	2,156	(8,102)	18,326	9
10	Fire protection work	6/30/1997	2,096	249	40	52	(197)	442	10
11	Elevators work	6/30/1997	1,595	190	40	40	(150)	340	11
12	Storage and moving cost	6/30/1997	19,125	2,275	40	478	(1,797)	4,063	12
13	Window treatment improvements	6/30/1997	14,142	1,682	40	354	(1,328)	3,009	13
14	Painting work	6/30/1997	212,678	25,299	40	5,317	(19,982)	45,195	14
15	Resilient flooring	6/30/1997	161,133	19,167	40	4,028	(15,139)	34,238	15
16	Acoustical treatment	6/30/1997	102,956	12,247	40	2,574	(9,673)	21,879	16
17	Ceramic tile	6/30/1997	8,396	999	40	210	(789)	1,785	17
18	Drywall	6/30/1997	11,049	1,314	40	276	(1,038)	2,346	18
19	Hardware	6/30/1997	54,460	6,478	40	1,362	(5,116)	11,577	19
20	Aluminum windows	6/30/1997	2,616	311	40	65	(246)	553	20
21	Roofing	6/30/1997	13,942	1,658	40	349	(1,309)	2,967	21
22	Wood door	6/30/1997	1,802	214	40	45	(169)	383	22
23	Unit masonry	6/30/1997	7,316	870	40	183	(687)	1,556	23
24	Cast in place concrete	6/30/1997	13,275	1,579	40	332	(1,247)	2,822	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,510,216	$ 310,883		$ 235,506	$ (75,377)	$ 1,654,289	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,510,216	$ 310,883		$ 235,506	$ (75,377)	$ 1,654,289	1
2	Disposer and wall heating and cooling units	7/1/1998	8,549		3			8,549	2
3	Roof covering and gutters	1/13/1998	4,345		3			4,345	3
4	Elevator repairs	6/30/1999	1,600		3			1,600	4
5	Elevator repairs	6/30/1999	15,078		3			15,078	5
6	Assets After 6/30/99:								6
7	Toilet replacement	7/1/1999	12,397		3			12,397	7
8	Toilet replacement	8/1/1999	1,194		3			1,194	8
9	Plumbing and electrical work	7/1/1999	4,100		3			4,100	9
10	Elevator repairs and electric	7/1/1999	31,402		3			31,402	10
11	Sidewalk repair	7/1/1999	1,892		3			1,892	11
12	Door holders	12/31/1999	4,784		3			4,784	12
13	Electrical panel repair	12/31/1999	4,900		3			4,900	13
14	Nurse call system	2/29/2000	9,083		3			9,083	14
15	Nurse call system	2/29/2000	54,480		3			54,480	15
16	Detail of building improvements 06/30/2000								16
17	General contractor cost	6/30/2000	22,010		40	550	550	2,475	17
18	Demolition cost	6/30/2000	622	16	40	16		68	18
19	Concrete cost	6/30/2000	2,119	53	40	53		242	19
20	Masonry cost	6/30/2000	2,223	55	40	55		251	20
21	Carpentry and fireproofing cost	6/30/2000	2,140	53	40	53		242	21
22	Roofing cost	6/30/2000	4,093	103	40	103		460	22
23	Entrance improvements	6/30/2000	1,583	39	40	39		179	23
24	Windows cost	6/30/2000	6,191	155	40	155		694	24
25	Hardware cost	6/30/2000	3,761	94	40	94		423	25
26	Drywall cost	6/30/2000	18,998	475	40	475		2,141	26
27	Ceramic tile and flooring	6/30/2000	12,892	323	40	323		1,450	27
28	Painting and decorating	6/30/2000	10,437	261	40	261		1,171	28
29	Kitchen and millwork improvements	6/30/2000	6,860	171	40	171		773	29
30	Plumbing and electrical work	6/30/2000	24,433	611	40	611		2,746	30
31	HVAC work	6/30/2000	16,892	423	40	423		1,900	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,799,274	$ 313,715		$ 238,888	$ (74,827)	$ 1,823,308	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,799,274	$ 313,715		$ 238,888	$ (74,827)	$ 1,823,308	1
2	Carpet	2002	2,035	293	7	293		729	2
3	Electrical	2002	5,722	284	20	284		713	3
4	Emergency generator system and facility rewiring	2002	919,934	45,996	20	45,996		114,991	4
5	First floor renovation	2002	367,252	18,363	20	18,363		45,907	5
6	Hot water heaters	2002	67,944	3,397	20	3,397		8,493	6
7	Nurse call system	2002	31,433	1,571	20	1,571		3,928	7
8	Mechanical (oxygen distribution system)	2002	38,241	1,912	20	1,912		4,780	8
9	Plumbing	2002	2,961	148	20	148		370	9
10	HVAC	2002	47,353	2,368	20	2,368		5,920	10
11	Painting and decorating	2002	21,585	1,079	20	1,079		2,698	11
12	Roof replacement	2002	99,498	4,921	20	4,921		12,329	12
13	Service elevator modernization	2002	44,119	2,206	20	2,206		5,515	13
14	Soft costs	2002	65,031	3,252	20	3,252		8,130	14
15	Mechanical	2002	54,389	2,720	20	2,720		6,799	15
16	Monument sign	2002	16,917	1,692	10	1,692		4,230	16
17	Site drainage	2002	59,341	2,967	20	2,967		7,418	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,643,029	$ 406,884		$ 332,057	$ (74,827)	$ 2,056,258	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,643,029	$ 406,884		$ 332,057	$ (74,827)	$ 2,056,258	1
2	Security cameras	6/30/2003	14,922	746	20	746		1,119	2
3	Electrical updates	6/30/2003	626	31	20	31		47	3
4	Electrical updates	6/30/2003	19	1	20	1		1	4
5	Electrical updates	6/30/2003	861	43	20	43		65	5
6	Electrical updates	6/30/2003	45	2	20	2		3	6
7	CDH PO# 174903 - project # 21165	6/30/2003	8,486	424	20	424		636	7
8	Miner & East	6/30/2003	14,740	737	20	737		1,106	8
9	Extractor	6/30/2003	556	28	20	28		42	9
10	Engineering	6/30/2003	4,470	224	20	224		336	10
11	Office renovation	6/30/2003	448	22	20	22		33	11
12	Labor	6/30/2003	56	3	20	3		4	12
13	Labor	6/30/2003	1,344	67	20	67		101	13
14	Emergency shower repair	6/30/2003	4,780	239	20	239		359	14
15	Electrical updates	6/30/2003	2,340	117	20	117		176	15
16	Cindy Smith	6/30/2003	663	33	20	33		50	16
17	Miner & East	6/30/2003	154,919	7,746	20	7,746		11,619	17
18	Miner & East	6/30/2003	8,563	428	20	428		642	18
19	Ice cream parlor	6/30/2003	679	34	20	34		51	19
20	Office renovation	6/30/2003	6,600	330	20	330		495	20
21	Office renovation	6/30/2003	448	22	20	22		33	21
22	Code regulation for storage	6/30/2003	15,195	760	20	760		1,140	22
23	Plumbing	6/30/2003	11,583	579	20	579		869	23
24	Dust control assembly	6/30/2003	1,220	61	20	61		183	24
25	Shower room repair	6/30/2003	1,877	94	20	94		282	25
26	Smoke / fire dampers	6/30/2003	1,954	98	20	98		293	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,900,423	$ 419,753		$ 344,926	$ (74,827)	$ 2,075,943	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,900,423	$ 419,753		$ 344,926	$ (74,827)	$ 2,075,943	1
2									2
3	Labor	6/30/2004	858	21	20	21		21	3
4	Engineering	6/30/2004	4,470	112	20	112		112	4
5	Skilled Nrsg Rev	6/30/2004	663	16	20	16		16	5
6	Skilled Nrsg Rev	6/30/2004	846	21	20	21		21	6
7	Supply desk	6/30/2004	556	28	10	28		28	7
8	C.S. Artwork	6/30/2004	122	6	10	6		6	8
9	CS Artwork	6/30/2004	33	1	10	1		1	9
10	Concrete Sealcoat	6/30/2004	1,796	90	10	90		90	10
11	Anderson Mikos Prof Srvcs	6/30/2004	3,735	93	20	93		93	11
12	Troyer Group Srvcs	6/30/2004	8,419	210	20	210		210	12
13	Anderson Mikos Prof Srvcs	6/30/2004	2,343	59	20	59		59	13
14	Anderson Mikos Prof Srvcs & Architect	6/30/2004	6,175	154	20	154		154	14
15	IDPA work	6/30/2004	3,180	79	20	79		79	15
16	Troyer Group Redecorating	6/30/2004	10,157	254	20	254		254	16
17	Hot Water Heater	6/30/2004	12,985	325	20	325		325	17
18	Troyer Group Redecorating - Phase I	6/30/2004	11,633	291	20	291		291	18
19	Troyer Group Redecorating - Phase I	6/30/2004	6,810	170	20	170		170	19
20	Troyer Group inv	6/30/2004	8,610	215	20	215		215	20
21									21
22	Unlocated variance on depr booked			27,267			(27,267)		22
23									23
24	Depreciation Allocated from DuPage Health					64,483	64,483		24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,983,814	$ 449,165		$ 411,554	$ (37,611)	$ 2,078,088	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 704,209	$ 94,290	$ 94,290	$	3-10yrs	$ 519,108	71
72	Current Year Purchases	76,888	6,496	6,496		5-7yrs	6,496	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 781,097	$ 100,786	$ 100,786	$		$ 525,604	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	1997 Ford Van Shuttle	1998	$ 45,524	$	$	$	4	$ 45,524	76
77										77
78										78
79										79
80	TOTALS			$ 45,524	$	$	$		$ 45,524	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,610,435	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 549,951	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 512,340	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (37,611)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,649,216	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 40,797 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A	N/A	$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C1&2	4309 hrs	$ 203,042		$	$ 3,355	4,309	$ 206,397	1
2	Licensed Speech and Language Development Therapist	L10a, C1&2	1610 hrs	71,193			34	1,610	71,227	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C1&2	7781 hrs	274,303			6,305	7,781	280,608	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, C2	# of prescrpts				516,312		516,312	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV Therapy	L10a, C3				50,094			50,094	13
14	TOTAL			$ 548,538		$ 50,094	$ 526,006	13,700	$ 1,124,638	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,149,939	$ 1,149,939	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,280)	1,046,200	1,046,200	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,132	154,132	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,350,271	$ 2,350,271	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,800,000	1,800,000	13
14	Buildings, at Historical Cost	13,270,339	13,270,339	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	826,621	826,621	16
17	Accumulated Depreciation (book methods)	(3,134,379)	(3,134,379)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Board Restr	539,855	539,855	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 13,302,436	$ 13,302,436	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,652,707	$ 15,652,707	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,087,314	$ 1,087,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	113,990	113,990	29
30	Accrued Salaries Payable	619,017	619,017	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Ins & Prof fees	529,562	529,562	36
37	Refundable Deposits	27,938	27,938	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,377,821	$ 2,377,821	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,523,195	6,523,195	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,523,195	$ 6,523,195	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,901,016	$ 8,901,016	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,751,691	$ 6,751,691	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,652,707	$ 15,652,707	48

***(See instructions.)**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,500,087	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,500,087	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(733,004)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (733,004)	17
	B. Transfers (Itemize):		
18	**Market Appreciation of Investmnts**	(15,395)	18
19	**Misc rounding**	3	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (15,392)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,751,691	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,253,310	1
2	Discounts and Allowances for all Levels	(3,139,724)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,113,586	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,874	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 12,874	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,438	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,438	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,157,898	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,774,263	31
32	Health Care	6,673,893	32
33	General Administration	3,789,033	33
	B. Capital Expense		
34	Ownership	802,686	34
	C. Ancillary Expense		
35	Special Cost Centers	736,285	35
36	Provider Participation Fee	114,742	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,890,902	40
41	**Income before Income Taxes (line 30 minus line 40)****	(733,004)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (733,004)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,875	2,092	$ 85,194	$ 40.72	1
2	Assistant Director of Nursing	1,947	2,092	74,329	35.53	2
3	Registered Nurses	61,476	96,612	2,268,484	23.48	3
4	Licensed Practical Nurses	13,041	20,890	346,198	16.57	4
5	Nurse Aides & Orderlies	124,433	208,389	2,087,085	10.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	12,568	13,699	548,539	40.04	7
8	Rehab/Therapy Aides	13,760	17,106	284,180	16.61	8
9	Activity Director	1,827	2,104	46,108	21.91	9
10	Activity Assistants	10,593	13,170	127,250	9.66	10
11	Social Service Workers	9,860	11,165	179,226	16.05	11
12	Dietician	1,537	1,924	40,243	20.92	12
13	Food Service Supervisor	5,760	8,141	116,483	14.31	13
14	Head Cook	6,834	11,027	96,287	8.73	14
15	Cook Helpers/Assistants	18,643	29,055	203,593	7.01	15
16	Dishwashers					16
17	Maintenance Workers	4,354	5,519	66,739	12.09	17
18	Housekeepers	30,177	44,713	308,680	6.90	18
19	Laundry	8,134	12,259	103,060	8.41	19
20	Administrator	1,843	2,092	131,089	62.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,533	14,889	245,745	16.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,761	5,774	94,586	16.38	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,992	4,332	60,516	13.97	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	349,948	527,044	$ 7,513,614 *	$ 14.26	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	194	$ 8,796	Ln 1, C3	35
36	Medical Director	Monthly	40,450	Ln 9, C3	36
37	Medical Records Consultant	62	2,294	Ln 10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	89	4,425	Ln 11, C3	44
45	Social Service Consultant	55	3,778	Ln 12, C3	45
46	Other(specify) IDPA NSG CNSLT	N/A	3,490	Ln 10, C3	46
47	Dietary Temps	70	1,045	Ln 1, C3	47
48					48
49	TOTAL (lines 35 - 48)	470	$ 64,278		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	385	$ 21,551	Ln 10, C3	50
51	Licensed Practical Nurses	359	15,201	Ln 10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	744	$ 36,752		53

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judith A. Perry	Administrator	0	$ 131,089
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 131,089

B. Administrative - Other

Description	Amount
Management Fees	$ 798,499
TOTAL (agree to Schedule V, line 17, col. 3)	$ 798,499
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Fenech & Pachulski, PC	Legal	$ 90
Sachnoff & Weaver Ltd	Legal	6,883
KPMG LLP	Audit & Acctg	15,073
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,046

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,978
Unemployment Compensation Insurance	20,864
FICA Taxes	523,788
Employee Health Insurance	882,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	36,585
Employee Recognition	7,249
Pension	228,222
MSP Savings Plan	54,098
Uniforms	1,357
Home Office Allocation	147,780
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,993,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network Dues	8,240
Nursing & Admin Subscriptions	4,519
Sectary of State	450
Dupage Cty Hlth	690
Misc Other	1,572
Allocation from Home Office	2,455
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,926

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
See Sch	718
In-State Travel	
See Sch	1,656
Seminar Expense	
See Sch	10,293
Home Office Allocation	4,432
Entertainment Expense	(718)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,381

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wynscape # 0041426 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Wynscape # 0041426 **Report Period Beginning:** 7/1/2003 **Ending:** 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of IL, $8240**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **87,789** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **114,742**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.